Medicare Fraud & Abuse

A Practical Guide of Proactive Measures to Avoid Becoming a Victim

HCFA
Health Care Financing Administration

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Fraud & Abuse - Introduction

Each year fraud and abuse in the Medicare program accounts for a substantial percentage of Medicare's annual spending. The estimated costs for Medicare fraud and abuse exceed $12 billion each year. In recent years, that estimate was as high as $23 billion. However, as a result of legislation which focuses on health care fraud and the federal government's commitment to combating it, this amount was reduced through increased prevention, education, detection, and enforcement.

The Health Care Financing Administration (HCFA) is emphasizing the prevention and early detection of fraud and abuse which may be identified by multiple sources including providers, beneficiaries, and other government agencies.

The billions of taxpayer dollars lost to health care fraud and abuse are the financial resources that should be used to pay for services that keep beneficiaries in good health. The Medicare contractors are aggressively working with the Health Care Financing Administration, the Federal Bureau of Investigations (FBI), the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit, and the United States Attorney's Office in dealing with these issues. In addition, Medicare is interacting with many provider and beneficiary advocacy associations to provide ongoing outreach education.

This book is designed to inform Medicare providers and healthcare organizations about the delicate situations they may encounter concerning potential fraud and abuse of the Medicare program.

The first chapter defines fraud and abuse in addition to providing examples of each situation to help better educate the provider and health care community. Chapter two explains the various actions that can be taken against health care providers found to be defrauding or abusing the Medicare program and its beneficiaries. Chapter three provides situations where caution should be exercised by providers before entering into relationships or situations where the appearance of fraud and abuse may be created. The fourth chapter discusses legislative issues and general definitions of various health care statutes related to Medicare. The fifth chapter provides readers with self checks that should help prevent situations where fraud and abuse might be misconstrued. The final chapters list some contacts and resources as well as a glossary of terms used throughout the book.

Medicare Is On Your Side

If this book raises questions in your mind about fraud and abuse or if you want to report what you believe are fraudulent or abusive activities, please contact Medicare and become a part of the solution.

Additionally, providers and healthcare organizations must be proactive in staying abreast of these issues to avoid becoming a victim themselves.

Anyone who suspects or would like to report potential fraud and abuse, should call or write to the local Medicare contractor, Customer Service Center, OR contact the following OIG National Hotline directly at: **1-800-HHS-TIPS.**

Although reports may be used during an investigation, they are held in the strictest confidence. Reports can also be made anonymously.

Internet Access

The entire Government Services Administration (GSA) debarment, exclusion, and suspension list is accessible on the internet at the following address:

www.arnet.gov/epls/

The Department of Health and Human Services (DHHS) also has an internet website that not only includes a database of sanctioned providers, but also information related to HCFA and OIG updates. It is accessible on the internet at the following address:

www.hhs.gov

The Medicare Learning Network has a computer based training module on Medicare fraud and abuse. This information can be accessed on the internet at the following address:

www.hcfa.gov/medlearn/cbts.htm

Chapter 1 – General Information

The Medicare program has become big business and has attracted - as big businesses sometimes do - a few unsavory characters. It is becoming more important than ever for providers to be cautious. This book is provided to help readers "stay on their toes by:

- enhancing their understanding of what Medicare fraud/abuse is and isn't;
- explaining the penalties that can be levied when fraud/abuse is committed; and
- providing guidance on protective measures that can be implemented to avoid fraud/abuse in several key areas of their health care organization.

What Is Fraud?

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Examples of Fraud

- Billing for services not rendered.
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- Using an incorrect or inappropriate provider number in order to be paid (e.g. using a deceased provider's number).
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment.
- Selling or sharing patients' Medicare numbers so false claims can be filed.
- Offering incentives to Medicare patients that are not offered to non-Medicare patients (e.g., routinely waiving or discounting the Medicare deductible and/or coinsurance amounts).
- Falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government.
- Misrepresenting as medically necessary, non-covered services by using inappropriate procedure or diagnosis codes.

What Is Abuse?

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Although many types of inappropriate practices may be considered abusive, they may evolve into fraud.

Examples of Abuse

- Using procedure or revenue codes that describe more extensive services than those actually performed.
- Collecting more than the 20% coinsurance or the deductible on claims filed to Medicare. Providers may, of course, bill patients for services not covered (e.g., service exclusions).
- Routinely submitting duplicate claims.

- Billing for services grossly in excess of those needed by patients. For example, always billing for complete lab profiles when only a single diagnostic test is necessary to establish diagnosis.
- Incorrectly apportioning costs on cost reports for Part A providers.
- Charging more than the actual purchase price of a service, item, or drug.

Chapter 2 – Actions That May Be Taken Against providers or Entities Who Commit Fraud or Abuse

When Medicare determines that fraud potentially exists, the case is developed via research and investigation then it is referred to the Office of Inspector General (OIG) or other law enforcement agency (e.g., FBI) for further investigation. The OIG then coordinates its investigation with other federal and state law enforcement agencies.

The following list describes actions that may be taken when fraud or abuse is identified.

Criminal Prosecutions & Penalties

Because it is a federal crime to defraud the United States Government or any of its programs, an individual may be sent to prison, fined or both. Criminal convictions usually include restitution and significant fines. In some states, providers and healthcare organizations may also lose their licenses. Convictions mandatorily result in exclusion from Medicare and other federal health care programs for a specific length of time.

Depending on the case, the U.S. Attorney's Office may use a variety of statutes to indict and prosecute the individuals and/or entities involved. Sometimes, a combination of two or more of the statutes may be used. Some of them are listed below:

- 18 U.S.C. Section 1347: Health care fraud
- 18 U.S.C. Section 669: Theft or embezzlement in connection with health care
- 18 U.S.C. Section 1035: False statements relating to health care
- 18 U.S.C. Section 1518: Obstruction of a Federal health care fraud investigation
- 18 U.S.C. Section 371: Conspiracy to commit fraud
- 18 U.S.C. Section 287: False claims
- 18 U.S.C. Section 1001: False statements
- 18 U.S.C. Section 201: Bribery
- 42 U.S.C. Section 1320: Kickbacks
- 18 U.S.C. Sections 1956-57: Money laundering
- 18 U.S.C. Section 1962: RICO Act
- 18 U.S.C. Section 1343: Wire fraud
- 18 U.S.C. Section 1341: Mail fraud

Civil Prosecutions & Penalties

In addition to or in lieu of criminal prosecutions, the U.S. Attorney may file a civil suit or may decide that the interest of the program is best served by settling the case. In these situations, the amount of damages plus additional money is paid to the government in the form of penalties and fines. These penalties may also include a permissive exclusion, which translates into not being permitted to bill Medicare and Medicaid for a specified number of years.

Civil Monetary Penalties

The Medicare and Medicaid Patient and Program Protection Act of 1987 authorizes the imposition of civil monetary penalties when it is determined that a person or entity has violated Medicare laws by submitting claims that cause violation of any of the following:

- Violation of the Medicare assignment provisions;
- A Medicare physician or supplier agreement violation;

- False or misleading information expected to influence a discharge decision;
- Violation of assignment requirement for certain diagnostic clinical laboratory tests;
- Violation of requirement of assignment for nurse-anesthetist services;
- Any supplier who refuses to supply rental durable medical equipment (DME) supplies without charge after rental payments may no longer be made;
- Physician billing for assistants at cataract surgery without prior approval of the Peer Review Organization (PRO);
- Hospital unbundling of outpatient surgery costs; and
- Hospital and responsible physician "dumping" of patients, based upon their inability to pay or lack of resources.

Typically, penalties involve assessments of significant damages such as civil monetary penalties up to $10,000 per violation, and exclusion from the Medicare program for a minimum of five years or more.

Actions Resulting from Kickbacks, Bribes, False Statements, and Rebates

Whoever ...

- Knowingly and willfully makes or causes to be made any false statement or representation of material fact in an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- Has knowledge of any event affecting his/her right to receive a benefit or affecting the right of another individual in whose behalf he/she receives such benefit, and fails to disclose such event with the intent to fraudulently secure greater amount or quantity than is due or when none is due;
- Receives benefits on behalf of another person and knowingly and willfully puts them to a use other than for the benefit of that person; or
- Furnishes items or services and solicits, offers, or receives a kickback, bribe or rebate of a fee...

... shall be guilty of a felony and upon conviction, shall be fined not more than $50,000 per violation or imprisoned for not more than five years per violation, or both.

Exclusion Authority

The OIG under the Department of Health and Human Services has the authority to exclude providers who have been convicted of a health care related offense. A mandatory exclusion exists if there is a conviction of fraud. In the absence of a conviction, the OIG may permissively exclude providers if certain conditions and requirements have been met. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may take action to exclude the provider from the Medicare program. Exclusion means that for a designated number of years, Medicare, Medicaid and other government programs will not pay the provider for services performed or for services ordered by the excluded party.

Mandatory Exclusions

Section 1128(a)(1) - Program related conviction
The OIG is required to exclude individuals and entities that have been convicted of a crime related to the Medicare or State health care programs. The minimum mandatory period of exclusion for these types of convictions is five years.

Section 1128(a)(2) - Conviction for patient abuse or neglect
The OIG is required to exclude individuals and entities that have been convicted of a crime relating to the abuse or neglect of a patient. The minimum mandatory period of exclusion for these types of convictions is five years.

Permissive Exclusions

Section 1128(b)(1) - Conviction relating to fraud
The OIG may exclude individuals and entities that have been convicted of certain types of crimes that are not directly related to the delivery of items or services under Medicare or the State health care programs. Convictions for fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct are covered by this section.

Section 1128(b)(2) - Conviction relating to obstruction of an investigation
The OIG may exclude any individual or entity convicted under Federal or State law of interference with, or obstruction of, any investigation into a criminal offense involving program-related convictions (sections 1128(a)(1) or (a)(2)) or fraud (section 1128(b)(1)). Some of the types of convictions covered by this section are perjury, witness tampering, and obstruction of justice.

Section 1128(b)(3) - Conviction relating to controlled substances
The OIG may exclude any individual or entity convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG limits sanctions under this authority to those individuals or entities that have a relationship to any health care activity.

Section 1128(b)(4) - License revocation or suspension
The OIG may impose an exclusion which will prevent a physician who has lost a license in any State from being reimbursed for treating program beneficiaries in every State, even if he has a license in another state. This section refers to licenses that have been revoked, suspended, or otherwise lost for reasons bearing on the individual's integrity. The term "otherwise lost" is intended to cover any situation where the effectiveness of the person's license to provide health care has been interrupted or precluded, regardless of the term used in a particular jurisdiction.

Section 1128(b)(5) - Suspension or exclusion under a Federal or State health care program
The OIG may exclude any individual or entity suspended or excluded from participation, or otherwise sanctioned, by a State health care program or any other Federal program involving the provision of health care for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity. The phrase "otherwise sanctioned" is intended to cover all actions which limit the ability of a person to participate in the program at issue, regardless of what such a sanction is called.

Section 1128(b)(6) - Excessive claims or furnishing of unnecessary or substandard items or services
The OIG may exclude an individual or entity which submits excessive claims, or furnishes unnecessary or substandard items or services, not only to Medicare and State health care program beneficiaries, but to any person. This section also provides for the exclusion of Health Maintenance Organizations and similar types of entities for failure to provide medically necessary items and services, where such failure has adversely affected, or has a substantial likelihood of adversely affecting, beneficiaries.

Section 1128(b)(7) - Fraud, kickbacks and other prohibited activities
The OIG may exclude any individual or entity that it determines knowingly and willfully solicited, received, offered, or paid any remuneration, i.e., fraud, kickbacks, and other prohibited activities.

Section 1128(b)(8) - Entities owned or controlled by a sanctioned individual
OIG may exclude entities if they are owned or controlled by individuals who have been convicted, who have had civil monetary penalties or assessments imposed against them, or who have been excluded from any of the programs under any exclusion authority.

Section 1128(b)(9) - Failure to disclose required information
The OIG may exclude any entity that did not fully, accurately, and completely make disclosures about individuals who have been convicted of theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct who are associated with that entity.

Section 1128(b)(10) - Failure to supply requested information on subcontractors and suppliers
The OIG may exclude entities who fail to respond to an OIG request for information on subcontractors and suppliers.

Section 1128(b)(11) - Failure to provide payment information
The OIG may exclude any individual or entity providing services to program beneficiaries if the party fails to provide payment information or refuses to permit examination and duplication of payment records in order to verify the information contained therein.

Section 1128(b)(12) - Failure to grant immediate access
The OIG may exclude any individual or entity that fails to grant immediate access upon reasonable request to certain agency representatives for review of documents related to performance of their statutory functions.

Section 1128(b)(13) - Failure to take corrective action
The OIG may exclude any hospital that HCFA determines failed substantially to comply with a corrective action plan required by HCFA. The HCFA regional office will provide the necessary information to the OIG who will then take the exclusion action.

Section 1128(b)(14) - Default on health education loans or scholarship obligations
The OIG may exclude any individual that the Public Health Service determines to be in default on repayments of scholarship obligations or loans.

Sanctioned and Reinstated Provider Lists

The OIG identifies individuals and entities that are excluded from reimbursement under Medicare through sanctioned provider lists. In addition to the identifying information pertaining to the sanctioned party, the list includes the specialty, notice date, sanction period, reason for sanction being imposed, and the sections of the Social Security Act used in arriving at the determination to impose a sanction. The OIG also lists the individuals and entities that have been reinstated to the Medicare program.

Internet Lists

The entire Government Services Administration (GSA) debarment, exclusion, and suspension list is accessible on the Internet at:

www.arnet.gov/epls/

This web site is updated daily to assist Medicare and Medicaid contractors when verifying the eligibility of health care providers and/or entities seeking to participate in the Medicare and Medicaid programs. Medicare encourages individuals and entities to research the information on this web site before adding a provider to a physician group or a medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from the Medicare program.

Payment Denials

Denial of Payment to an Excluded Party

Medicare payment will not be made to an excluded individual or entity who has accepted assignment nor to a beneficiary submitting claims for items and services furnished on or after the effective date of a sanction. In addition, payment will not be made for services/items furnished on the order or referral of an excluded individual or entity.

Denial of Payment to a Supplier

Medicare payment will not be made to a supplier (e.g., durable medical equipment supplier or laboratory) that is wholly owned by an excluded party for items and services furnished on or after the effective date of the sanction.

Denial of Payment to a Provider of Service

Medicare payment will not be made to a provider for services performed or items received, including services performed under contract, by an excluded party or by a supplier which is wholly owned by an excluded party on or after the effective date of the sanction.

Denial of Payment to Beneficiaries

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier which is wholly owned by an excluded party on or after the effective date of the sanction:

- Medicare payment may be made for the first claim submitted by the beneficiary and the Medicare program will immediately give the beneficiary notice of the sanction; and
- The Medicare program will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary.

Exceptions

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- Inpatient hospital services or post hospital skilled nursing facility services or items furnished to a beneficiary who was admitted to a hospital or skilled nursing facility before the effective date of the sanction; and
- Home health services or items furnished under a plan of treatment established before the effective date of the sanction.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P. L. 100-93) does permit payment for an emergency item or service furnished by an excluded individual or entity.

Reinstatement

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare program and may apply to the OIG for reinstatement.

Whistle Blower Cases

The “Whistle Blower,” or “*qui tam”* provision as it is formally called, allows persons having knowledge of a false claim against the government to bring an action against the suspected wrong doer on behalf of the United States Government. Any person who files a *qui tam* suit on behalf of the government, known as a “relator,” may share a percentage of the recovery realized from a successful action.

Case Examples

Here are a few examples of actions the government took in actual cases involving Medicare providers:

- An unlicensed physician utilized the provider numbers of other physicians, without their knowledge, to bill Medicare for services not rendered. The doctor pled guilty in Federal court to money laundering and filing false claims. He was sentenced to 18 months in prison and required to pay the government in excess of $750,000.
- A psychiatrist billed Medicare and private insurers for services which were upcoded or not rendered. He pled guilty in Federal court to mail fraud and filing false claims and was sentenced to seven and one half months in Federal prison, seven and one half months of house arrest and three years probation. He was also directed to pay $600,000 in fines, restitution and investigative costs.
- The owner of a "Medicare mill" (a group that aggressively seeks out Medicare patients) and its ten employees admitted to cheating the government out of $3.3 million by billing for services which were unnecessary or never rendered. The persons involved in the scheme included a physician, a receptionist, patient recruiters and the clinic owner. Sentences are currently pending.
- An unlicensed doctor cheated the government for three years by billing Medicare for visits to homebound patients using other physicians' Medicare provider numbers. He pled guilty to money laundering and, as a result, had to forfeit his home, many acres of undeveloped property, a late-model luxury car and a year-old cabin cruiser. This property is worth an estimated $750,000 (about half the amount he is accused of receiving from Medicare). He also faces up to ten years in prison.
- Institutional providers separately billed Medicare for non-physician outpatient services provided in conjunction with inpatient admissions. These providers were collectively cited for possible estimated damages in excess of $30 million, including recovery of duplicate payments, liability for penalties, and treble damages of not less than $5,000 per claim.

Incentive Reward Program

As a result of the Health Insurance Portability and Accountability Act of 1996, a program was established to encourage individuals to report information on individuals and/or entities who are or have been engaged in fraudulent activities that could result in sanctions under any federal health care program.

Under the Incentive Reward Program, Medicare may make a monetary reward for information that leads to a minimum recovery of $100 of Medicare funds that were inappropriately obtained. The amount of the reward can be 10 percent of the amount recovered or $1000, whichever is less.

Contractor and HCFA Actions

In addition to the possible actions that may be taken by the federal government such as prosecutions, the contractor and HCFA also have a responsibility to ensure that all claims paid are appropriate.

Suspension of Payments

In January 1997, HCFA assumed the responsibility to suspend payments to any provider if fraud is suspected or if a potential overpayment exists and there is reasonable evidence that the overpaid amounts would not be refunded. HCFA instructs the contractor to withhold all monies for claims approved for payment up to 180 days. If, after the first 180 day period, fraud is still suspected, HCFA can authorize the contractor to continue to withhold payments for an additional 180 days. If, after the first year, fraud is still suspected, the U.S. Attorney, through HCFA, can instruct the contractor to withhold all payments to a particular provider or entity indefinitely. The provider or entity may submit rebuttals for suspension actions in cases of suspected fraud directly to HCFA for consideration in lifting the suspension.

In cases where Medicare has evidence that an overpayment may not be repaid by a provider, the contractor may withhold payments until the overpaid amounts are recovered. Rebuttals to this suspension activity should be directed to the contractor.

Flag or Focus Review

The contractor may decide to review a provider's claims *prior to payment.* In cases of this type of prepayment review (called *focus* for Part A providers and *flag* for Part B providers), the provider is notified by Medicare and instructed as to what type of documentation is needed for a detailed review of the claims.

Comprehensive Overpayments

Often, Medicare determines that an entire organization will be reviewed. In these cases, a letter requesting specific documentation for selected codes and/or patients is sent to the provider. Once received, the documentation is used to determine if an overpayment exists.

Education

In many instances, inappropriate billings or patterns of errors can easily be corrected by education. If it is determined that a provider may not understand billing and/or coverage guidelines and it is apparent that there is no fraud involved, the contractor may initiate or suggest an educational plan or corrective action plan for the provider so that they can become compliant with Medicare guidelines.

Provider Enrollment Department

Nationally, Provider Enrollment Departments have taken active roles in protecting the Medicare Program from potential fraud and abuse. Since 1995, they have conducted on-site visits to providers' offices and facilities. The sole purpose of such visits is to verify the information supplied on the provider's application to Medicare. Although granting access to this Medicare representative is voluntary, failure to allow access may result in denial of an application for a provider number or the cancellation of a current Medicare provider number.

During these visits, the Medicare representative may request to view all required federal, state, county or local licenses. Medicare providers are required to obtain and maintain such licenses and have them available for review by a Medicare representative.

If there are any changes to information included in original applications for Medicare provider numbers, notify the applicable Provider Enrollment Department. Examples of such changes may include: address change, change of ownership, change in the name of the business, or change in the Tax ID#. Failure to provide notification may result in temporary cancellation of the provider number thereby preventing payments from Medicare.

Reassignment of Benefits

Medicare must make payment directly to the physician or other supplier who furnished the service(s) except in the following situations:

Payment to employer - Medicare may pay the employer of a physician or other supplier if the physician or other supplier is required, as a condition of their employment, to turn over to their employer the fees for the services.

Payment to facility - Medicare may pay the facility in which the service was furnished if there is a contractual arrangement between the facility and other supplier under which the facility bills and receives payment for the services.

Payment to health care delivery systems - Medicare may make payment to a health care delivery system if there is a contractual arrangement between the system and the physician or other supplier under which the

system bills for the physician's or other supplier's services. In order to be considered a health care delivery system, an organization must be either a clinic, a carrier dealing prepayment organization, a direct dealing health care prepayment plan, or a direct dealing HMO or competitive medical plan.

For the purpose of receiving payment under reassignment as a health care delivery system, a clinic must be a freestanding entity which provides diagnostic and/or therapeutic medical services on an outpatient basis in quarters which it owns or leases. The clinic would be able to bill and receive payment for services of independent contractor physicians for services provided on the clinic's premises. For services provided off the premises, either the physician must bill directly to Medicare or the facility where the services were provided must bill under their name and number.

The Health Care Financing Administration (HCFA) developed the following definition for a medical group: "*Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and wish to bill Medicare as a unit. This excludes contracted physicians, non-physician practitioners and other contracted health care providers/suppliers. A group has individual members. The individual members must be enumerated and enroll in the Medicare program as an individual in order to enroll as a member of the group. A group can only be enrolled if it can meet the conditions for reassignment."*

Medicare has developed stringent criteria which must be met in order to allow a physician to reassign their Medicare benefits to a health care delivery system. If it is determined that the criteria are not met, the request may be denied (in case of a new application), or the physician's eligibility to reassign their benefits to a particular facility will be terminated if previously allowed.

Non-physicians may also reassign their benefits to a health care delivery system. The group or clinic for which they wish to reassign their benefits must meet the established criteria for a health care delivery system.

There have been many questions raised as to whether a physician may reassign Medicare benefits to an agent who is acting on behalf of the physician. Medicare laws do not allow a reassignment of benefits to an agent, but the Medicare Program may make payment in the name of the physician (or other supplier or party eligible to receive the payment) to an agent who furnishes billing or collection services if:

- The agent receives the payment under an agency agreement with the physician;
- The agent's compensation is not related in any way to the dollar amounts billed or collected;
- The agent's compensation is not dependent on the actual collection of payment;
- The agent acts under payment disposition instructions which the physician may modify or revoke at any time; and
- In receiving the payment, the agent acts only on behalf of the physician (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection of services).

Chapter 3 – Protect Yourself

The following situations should be approached with caution to ensure that Medicare guidelines are followed.

Billing Services and Consultants

If a provider or entity understands the key attributes of a reliable billing or consulting service, informed decisions about whether a particular service is right for you should be fairly simple. **Remember, providers and entities are responsible for their claims even when using billing services or consultants.**

A billing service is a company that generally handles claims filing to various insurance companies for providers and/or suppliers. There is usually a per-claim charge or a percentage-of-total-claim amount charge to the provider. Some billing services will collect paper claims from a provider/supplier location and forward the claims electronically to the carrier from their host computer systems. Other billing services supply the provider with billing software and/or a computer terminal for claims entry and submission to the billing service host computer which then forwards the claims to the appropriate insurance company. Like any other service you are shopping for, you have specific criteria or requirements that are needed for your particular organization.

Cost

Cost options differ, so it is important that providers and suppliers look at the amount typically charged per claim and overall claims volume in order to understand the total cost.

- *What is the cost per claim or percentage of total billed/allowed?*
- *If the computer is installed in my office, what will the rental/lease fee be?*

Insurance Companies

Providers and suppliers may have to file claims to a variety of insurance companies and want them filed consistently whenever possible. Ensure that the billing service/consultant takes preventive measures to protect the confidentiality of both patient and provider data used in the submission of claims.

- *Which insurance companies does the service submit bills to?*
- *Can the claims be submitted to these insurance companies in the manner I choose (i.e., paper or electronically)?*
- *Is there a difference in the charges between paper and electronic submission?*

Completeness and Accuracy of Claims

Ensuring that claims are submitted as accurately and error-free as possible is a virtual guarantee of the quickest payment possible. However, use of a billing service/consultant does not relieve a provider or supplier of the accountability to ensure the appropriateness of the services billed.

- *Will I be able to include specific types of records/documentation required by each Medicare contractor or insurance company for claims processing? (e.g., crossovers, MSP documentation, medical necessity documentation for chiropractic, podiatry, ambulance services, etc.)*
- *What edits does the billing service have installed in its claim submission software? Are all Medicare front end edits installed in the electronic module?*

Convenience

As with any service, convenience is certainly a consideration when deciding whether to engage a billing service or consultant.

- *How will the claims be transported/submitted to the billing service? (e.g., Do I need to send completed paper claims to the billing service or is this done electronically? If I bill paper claims, will the billing service make arrangements to pick them up?)*
- *Does the billing service/consultant expect me to complete the claim form in its entirety or will they take the patient's claim information and complete the claim form for me?*

Contractual Arrangements

Numerous legal and compliance factors must be considered when contracting with billing services and consultants.

- *What types of agreements and paperwork need to be executed between the provider and billing service/consultant?*
- *Are there any agreements/ paperwork required between the provider and the insurance companies?*

Timeliness

Unfortunately, not all billing services and consultants submit claims immediately upon receipt from their clients. Since some insurance carriers, including Medicare, make payment based on the date a claim was received, this criteria is an important factor due to its impact on receipt of your payments.

- *How soon will the claim be filed to the insurance companies after being submitted to the billing service?*
- *Can a claim which is rejected due to front-end edits or denied by an insurance company be re-filed electronically? If so, is there a charge for this service?*

Record Retention

If a provider or supplier needs to know what is happening during each step of the claims processing cycle, the following question should be asked:

- *Will I receive copies of the claims summary and confirmation after a claim is filed?*

Medicare believes that this information will be helpful to you in determining whether a billing service or consultant is right for you and which offers the features and capabilities which best suit your needs. For more information on billing services, consultants, or other electronic claim submission opportunities, please contact the Medicare Customer Service Center.

Obtaining a Medicare Billing Number

In order to bill Medicare directly providers must first obtain a provider identification number (PIN). These numbers are issued for your use in billing Medicare for services rendered. Protect it like a credit card number. Ensure that others don't use this number to bill Medicare without your knowledge.

Authorizing Another Entity to Bill Medicare and Receive Payments on Your Behalf

Generally speaking, Medicare pays the provider that performed the service. In limited situations, however, Medicare may allow the performing provider to reassign Medicare payments to another entity. This is called "reassignment of benefits" and requires that various forms be completed, signed and returned to the Medicare Registration Department. A fully executed "reassignment of benefits" form is powerful because it allows another person or entity to bill Medicare on the provider's behalf and receive payments that otherwise would have been sent directly to the provider. Have you authorized someone else to bill and be

paid by Medicare for services that you or your organization render? If so, you must be certain to ensure that such billings are appropriate and reflect services you actually performed.

Changing Your Billing Arrangements

Providers and suppliers may formally revoke the "reassignment" agreement by writing directly to the Medicare Registration Department. Failure to revoke outdated agreements allows that entity to continue to bill Medicare. Be certain that you have notified Medicare if your reassignment agreements are outdated or no longer valid.

Hiring Someone to Prepare Your Claims

As previously mentioned, some physicians and hospitals find it helpful to engage the services of a billing service or consultant to submit their Medicare claims. While such entities can provide valuable services, they should be engaged with caution. Delegating your entire claims preparation process does not protect you from being held responsible for the Medicare payments that are generated from the claims they file on your behalf. Before hiring a service or consultant, be certain to carefully check references and ensure that they:

- Provide periodic reports of claims it has billed on your behalf and, if the billing service receives your Medicare payments, how much Medicare paid;
- Protect your provider number and any other information used to act on your behalf;
- Do not change procedure codes, diagnostic codes or other such information furnished by you or your organization without your knowledge and consent; and
- Keep you informed of all correspondence received from Medicare.

Review these reports regularly to ensure consistency with your records. Also, keep complete administrative records for the claims that the billing service files on your behalf for seven years.

Hiring New Employees

Recent estimates for employee theft in the U.S. are approximately $50 billion each year. This fact combined with the provider's responsibility for the actions of their billing staff makes it critically important that your organization hires competent and ethical employees. Screen applicants carefully and develop internal controls within your organization in order to minimize risk. Install checks and balances in your organization's procedures to ensure the appropriateness of your interactions with Medicare. In addition, conduct periodic quality checks of sensitive processes such as the posting of account receivables.

Lost or Stolen Medicare Cards

Did you know that Medicare receives thousands of calls and letters from beneficiaries stating their Medicare cards have been lost or stolen and used by others?

Beneficiary impersonators are becoming more common as the cost of health care rises and people feel forced to resort to other measures to obtain necessary health care. As a result, HCFA is requesting that providers take action to avoid becoming victims.

One suggestion is to make a copy of each beneficiary's driver's license or some other form of valid identification and keep it on file. By doing so, office staff can quickly look at the picture on record to ensure that the patient receiving the service is actually the beneficiary named on the Medicare card.

Providers should beware of receiving false, fake, and fabricated Medicare cards as well as receiving false address and telephone information from their patients.

Remember it is the provider who is ultimately responsible for the verification of the identity of each patient receiving services from them. If services are rendered to a beneficiary impersonator, providers may be liable for an overpayment.

Offers of Free or Discounted Services

If a provider advertises services or a portion of services for free, the services cannot be billed to Medicare or any secondary policy.

Medicare requires that beneficiaries pay co-insurance on most services. Providing the service at no charge to the beneficiary, but billing Medicare (or both Medicare and the patient's secondary insurer) constitutes a routine waiver of co-insurance and is considered unlawful.

However, the waiver of co-insurance or deductibles would not be considered unlawful in instances when the beneficiary is unable to pay (e.g., indigent, poverty) and the information is documented in the patient records.

Documentation

If a service is not documented, one can argue it didn't happen. There are numerous situations that may warrant the need to present documentation for services rendered. Document the service as close to when the service was furnished as possible. Late entries arouse suspicion and increase the likelihood of inaccuracies.

Closing or Relocating

Medicare Part A Providers

Providers or suppliers wishing to obtain application information or to make changes to an existing application or file must contact the state agency responsible for licensure and certification.

Medicare Part B Providers

Inform your Medicare contractor if you decide to close or move your practice. Your PIN should be updated in Medicare's system so that it cannot be used by another provider or entity. Please write to your Medicare Registration Department.

Staying Informed of Medicare Changes

Because there are constant changes in Medicare, it is important that mechanisms are in place at your organization to ensure that you remain abreast of those changes that affect your services. Explanations such as "I didn't know about that change," or "the staff is responsible for keeping up with billing changes" are not considered good excuses. Providers are not only responsible for the quality of the health care they or their organizations render, but also for knowing current Medicare billing requirements. Carefully review the provider bulletins and any other publications from Medicare.

Procedure Code Selection

Choose billing and revenue codes carefully and solely on that which is supported in the documentation. If this responsibility is delegated, be sure that staff understands the principles of coding. Perform periodic

quality checks to ensure agreement with the codes being selected. Review coding manuals carefully to better ensure proper code selection.

Remember, providers are responsible for the claims prepared and submitted on their behalf.

Overpayment Issues

Medicare strives to ensure the accuracy of its payments, but occasionally mistakes occur. There are different methods of handling overpayments for Part A and Part B. If a Part A provider is erroneously paid for services not performed or is incorrectly paid for any other reason, overpayments should be resolved through the credit balance reports. If a Part B provider, return the money to Medicare immediately. Do not hold onto incorrect payments. In addition to interest and penalties that may be imposed on overpaid monies, the intentional withholding of an identified overpayment may be considered fraud.

Compliance Programs

In an effort to engage the health care community in combating fraud, waste, and abuse, the Department of Health and Human Services, Office of the Inspector General (OIG) issues guidance on compliance programs. In formulating the guidance, the OIG works closely with the Health Care Financing Administration (HCFA), the Department of Justice (DOJ), and various sectors of the health care industry. Based on their work, the OIG has identified seven fundamental elements to an effective compliance program:

- Implementing written policies, procedures, and standards of conduct;
- Designating a compliance officer and compliance committee;
- Conducting effective training and education;
- Developing effective lines of communication;
- Enforcing standards through well-publicized disciplinary guidelines;
- Conducting internal monitoring and auditing; and
- Responding promptly to detected offenses and developing corrective action.

Although compliance programs are strictly voluntary, adopting one could be beneficial to a health care provider or any entity involved in the health care industry. Implementing a compliance program could assist them in establishing a culture within their organization that promotes prevention, detection, and resolution of instances that do not conform to Federal or State law, and Federal, State, or private payor health care program requirements, as well as ethical business conduct.

Those interested in implementing a compliance program based on the OIG's published guidance must understand that although there is basic procedural and structural guidance for designing and implementing a compliance program, the guidance in itself is NOT a compliance program. Rather, it is a set of guidelines for consideration in implementing such a program. The compliance program should effectively articulate and demonstrate the provider's or entity's commitment to legal and ethical conduct. Eventually, a compliance program should become part of the provider's or entity's routine operations. However, having a compliance program in place does not provide the health care provider or other organization with immunity from scrutiny and/or corrective action by the government or any Federal, State, or private payor health care program.

The documents issued by the OIG on compliance program guidance are published in the *Federal Register* and are also on the Internet at:

www.dhhs.gov/progorg/oig.

Special Notes for Physician Referrals

Providers sometimes need to refer patients for more specialized medical care or to receive certain diagnostic tests or supplies. In such cases, providers should do the following:

- Implement a process that helps ensure that only the services or tests ordered were rendered. (e.g., when reviewing the results of lab tests, note whether tests over and above those ordered were performed by the lab.)
- Whenever possible, specify the reason the services are being ordered. If lab tests are ordered as part of a routine physical exam, include that fact with your referral. Do not empower the lab who files the Medicare claim to determine why the tests were needed.
- Never sign blank certification forms that are used by suppliers to justify Medicare payment for home oxygen, wheelchairs, hospital beds, prosthetic devices, etc. Personally complete all medical information on such forms. Additionally, any demographic information, such as the patient's name and address should be fully completed before signing the form.
- Medical supplies and devices are sometimes aggressively marketed to beneficiaries with little regard for the beneficiary's medical condition. Examples of aggressively marketed items include TENS devices and power operated scooters. While these devices can be helpful for some beneficiaries, you should use extreme caution when prescribing them in light of the creative ways they are sometimes marketed.
- Where applicable, specify the quantity of medical supplies you believe are needed for your patients. An open-ended certification is like giving someone a blank check. Medicare has seen recent examples of suppliers providing supplies that were, in fact, certified by a physician but delivered in staggering quantities.
- Be suspicious if an entity offers you discounts, free services or cash to order services. If a deal sounds too good to be true, it probably is. You should contact the Department of Health and Human Services' Office of the Inspector General or a health care attorney if you think one of your current business arrangements places you at risk. The penalties for violating Medicare's anti-kickback laws can be severe. At the time of this writing, labs have paid the largest fines but physicians and hospitals have been prosecuted as well.
- Never certify the need for medical supplies for patients you have not seen and examined.

Special Issues For Lab Providers

Clinical Laboratory Profiles

Some physicians who order clinical laboratory profiles from independent laboratories are supplied with check lists to order profiles or panels. While this may seem efficient, physicians must ensure that **each** service ordered is medically necessary, appropriate for the care and treatment of the patient, and clearly documented in the patient's medical record.

Some independent and/or hospital-based laboratories supply forms which allow physicians to order clinical laboratory profiles based on what may be most convenient for the laboratory's testing equipment as opposed to what the physician actually needs to establish a diagnosis. In actuality, this results in the submission of inappropriate claims to Medicare. To prevent this from occurring, physicians should not check the profile box if the laboratory does not give an option for the individual tests included in the profile, unless all tests in the profile are medically necessary. In these cases, providers should list each test that is to be performed. By listing the appropriate tests, only those tests that were medically appropriate and ordered by the physician may be billed and reimbursed.

Changes in Automated Lab Panels

Effective January 1, 1998, the Health Care Financing Administration revised the coding requirements for clinical laboratory services. A new reimbursement methodology has been developed as well. The following criteria is applied when calculating reimbursement for automated multi-channel tests:

- When two or more component tests are billed separately, they will **not** be grouped into panel codes and will be reimbused separately.
- Reimbursement for laboratory tests, automated or not, will be based on the total number of tests allowed.

The following list contains some of the tests which may be, and frequently are, performed as groups and combinations on automated profile equipment:

- Alanine aminotransferase (ALT, SGPT)
- Albumin; serum
- Alkaline phosphatase
- Aspartate aminotransferase (AST, SGOT)
- Bilirubin, total
- Bilirubin, direct
- Bilirubin, total and direct
- Carbon dioxide (bicarbonate)
- Calcium; total
- Chloride; blood
- Creatinine; blood
- Creatine kinase (CK, CPK); total
- Cholesterol, serum; total
- Glucose; quantitative
- Glutamyltransferase, gamma (GGT)
- Lactate dehydrogenase (LDH, LD)
- Phosphatase, acid; total
- Phosphorus, inorganic (phosphate)
- Potassium, serum
- Protein, total, exept refractometry
- Sodium, serum
- Triglycerides
- Urea nitrogen (BUN); quantitative
- Uric acid; blood

Medicare pays only for those services which are medically necessary for the patient and usually does not cover tests for screening purposes. Providers should target their orders to only those tests that are related to specific symptomatology or disease conditions. Claims will be reviewed for patterns of high use of automated profiles. During the review, if it is determined that medical necessity was not met for the profiles, an overpayment may be requested.

Special Payment Policies

EKG and X-Ray Interpretations

When there is a need to provide medically necessary x-ray or EKG services for a patient in the emergency room, Medicare will enforce the following guidelines:

- Payment will be made for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. The interpretation billed by the cardiologist or radiologist is payable if the interpretation of the procedure is performed concurrently with the diagnosis and treatment of the beneficiary, or if it is the only bill received.

- Hospitals are encouraged to work with their medical staff to ensure that only one claim per interpretation is submitted. Medicare may determine that the hospital's repeat reading is for quality control and liability purposes only and is a service to the hospital rather than to an individual Medicare beneficiary. Such services are not covered under Medicare.

Facility Fee Schedule Payments

Amendments to the Social Security Act required HCFA to develop a new methodology for determining a specific component used in calculating the Medicare Physician Fee Schedule (MPFS). As a result, the term "site of service differential" has been replaced by Facility Fee Schedule Payments. Facility Pricing Rules require physician services that are primarily performed in office settings to be subject to payment limits when performed in the following settings: inpatient or outpatient hospital; emergency room; comprehenvise inpatient or outpatient rehabilitation facility; skilled nursing facility; inpatient psychiatric center; or ambulatory surgery center.

Since this new methodology will significantly impact MPFS reimbursement rates, the Balanced Budget Act of 1997 authorized phasing in the new payment methodology over a four-year period, beginning January 1, 1999. By the year 2002, all MPFS payments will be calculated utilizing this new methodology.

A national list of procedures subject to the facility fee schedule pricing is established annually. Refer to the Medicare Physician Fee Schedule for services included in the Facility Pricing Rules.

Failure to report the correct place of service when providing medically necessary care to a patient is considered an attempt to intentionally commit fraud.

Special Rules for Deceased Beneficiaries

When a beneficiary dies before a claim has been settled, payment may be made on either an assigned or a non-assigned basis.

Assigned claims - Medicare can pay for services as long as the services were not previously processed on a non-assigned claim and the payment negotiated.

Non-assigned claims - If Medicare is notified of the beneficiary's death before a claim is finalized, payment will be made to the "Estate of (the deceased beneficiary)," if there is no legal representative. This will occur regardless of whether the provider's bill was paid by the beneficiary as long as it does not necessitate requesting additional information.

Medicare does not pay for services rendered to patients after they have expired.

Routine Services in Hospital or Skilled Nursing Facilities (SNF)

Routine inpatient services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge, commonly referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCUs), including coronary care units and intensive care units. Included in the routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are determined separately. If the

unit does not meet the definition of a special care unit, then the cost of such service cannot be included in a separate cost center and must be included in the general routine service cost center.

Consolidated Billing for Skilled Nursing Facilities

The Balanced Budget Act of 1997 (BBA) revised the reimbursement methodology for skilled nursing facilities. Effective for cost reporting periods beginning July 1, 1998, section 4432 of the BBA requires all skilled nursing facilities to be reimbursed under the Prospective Payment System (PPS). Under PPS, the payment rates will consolidate all costs of furnishing covered skilled nursing services (e.g., routine, ancillary, and related costs). Consolidated billing requires services provided to beneficiaries in a covered Part A facility to be billed by the skilled nursing facility.

Consolidated billing, for skilled nursing facilities whose cost reporting period begins on or after July 1, 1998, includes services provided by certain individuals and suppliers other than those employed by the skilled nursing facility, such as: orthotics or prosthetics; ostomy or colostomy supplies; sterile dressings or surgical dressings and supplies; enteral or parenteral nutrition and supplies; independent laboratories; portable x-ray suppliers; independent laboratories; therapy professionals rendering physical, occupational, or speech therapy services; and certain ambulance services. Services excluded from consolidated billing under PPS are:

- Physician services;
- Physician assistant working under physician supervision;
- Nurse practitioner and clinical nurse specialist working in collaboration with a physician;
- Certified nurse midwife services;
- Qualified psychologist services;
- Certified registered nurse anesthetist services;
- Home dialysis supplies and equipment, self-care dialysis support services and institutional dialysis services and supplies;
- Erythropoietin (EPO) for certain dialysis patients; and
- Certain services such as cardiac catheterization, computerized axial tomography scans, magnetic resonance imaging, emergency services, radiation therapy, and ambulatory surgeries involving the use of an operating room.

Physicians may continue to bill Medicare Part B directly for physician services provided to beneficiaries who reside in a skilled nursing facility. Examples of physician services include visits, consultations and surgical procedures.

A skilled nursing facility on PPS that is billing for a beneficiary during a covered Part A stay must use the following guidelines:

- The skilled nursing facility will be responsible for billing the Medicare Intermediary for all covered Part B services.
- The provider or supplier of services will be responsible for seeking payment directly from the skilled nursing facility.

If the patient is not in a covered Part A stay, providers and/or suppliers may bill Medicare Part B directly for the services rendered.

Covered Routine Personal Hygiene Items and Services in a SNF

In October 1995, the Health Care Financing Administration (HCFA) issued Transmittal No. 340 to the Medicare Skilled Nursing Facility (SNF) Manual (HCFA Publication 12), stating that:

"*routine personal hygiene items and services required to meet the needs of residents are covered items and services.*"

These items and services include, but are not limited to:

- Hair hygiene supplies,
- Combs and brushes,
- Bath soaps,
- Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or fight infection,
- Razors and shaving cream,
- Toothbrushes and toothpaste,
- Denture adhesives and denture cleansers,
- Dental floss,
- Moisturizing lotion,
- Tissues, cotton balls, and swabs,
- Deodorant,
- Incontinence care and supplies,
- Sanitary napkins and related supplies,
- Towels and wash cloths,
- Hospital gowns,
- Over-the-counter drugs,
- Hair and nail hygiene services,
- Bathing, and
- Basic personal laundry.

HCFA's instructions clearly convey that **SNF providers are not to bill *"ancillary charges for routine supply and pharmacy items."*** In other words, even though these items and services are covered, they are not separately billable via the HCFA-1450 (UB-92) billing format.

Sections 2202.6 and 2203.0-2203.3 of the Medicare Provider Reimbursement Manual (HCFA Publication 15) describe routine and non-routine items. In accordance with HCFA's instructions, any item which is classified as routine should always be included in the room and board charge. Therefore, SNF providers should review their charge masters and make any necessary changes in their billing procedures to ensure compliance with HCFA instructions.

SNF providers may not bill ancillary charges (or separate line item charges) for any routine supply and/or pharmacy items. Further, providers may not bill beneficiaries for these routine items and services, since these covered items and services are included in the provider's room and board charges.

Duplicate Claims May Be Considered Program Abuse

Approximately six percent of all claims filed to Medicare are denied as duplicate claims.

This represents an unnecessary waste of federal funds and is a target area for elimination by HCFA. Whenever possible, Medicare works with providers to eliminate duplicate claims.

Duplicate claims submission can occur from time to time; however, Medicare expects this rate to be less than one percent of all claims processed. Providers submitting the most duplicate claims will be identified and will be working with the Medicare contractor to learn about the various alternatives to duplicate filing.

Although determined on a case by case basis, Medicare may remove providers that continue to submit duplicate claims from the electronic billing network.

Special Issues For Medicare Part A Providers

DRG Payment Window

Under the prospective payment system (PPS), Medicare reimburses hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a Diagnosis Related Group (DRG). The prospective payment system provides a payment amount for inpatient operating costs which includes certain pre-admission services furnished by the hospital or by an entity wholly owned or operated by the hospital to the patient during the three days immediately preceding the date of the patient's admission to the hospital.

The specific pre-admission services (other than ambulance services) included in the inpatient hospital operating costs are the following:

- Effective with the implementation of the prospective payment system (PPS), any outpatient service provided within 24 hours of an admission should be included in the DRG.
- Diagnostic services (including clinical diagnostic laboratory tests) furnished within 72 hours should be included within the DRG. **It is important to note that these services do not have to be related to the inpatient admission.**
- Other services related to the admission furnished within 72 hours should be included in the DRG claim. Other services related to the admission means services, other than diagnostic services, that are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient.

There is a one day payment window in effect for PPS-exempt hospitals and units.

Discharge vs. Transfer

When PPS was developed, the regulations provided a distinction between discharges and transfers. Discharges were defined as situations in which a patient leaves an acute care hospital after receiving complete treatment, while transfers were those situations in which the patient is transferred to another acute care hospital for related care. The Balanced Budget Act of 1997 expanded the scope of transfer cases to include PPS Exempt Facilities (e.g. psychiatric, rehabilitation, long term care, children's hospitals, and cancer hospitals); skilled nursing facilities (excluding swing beds); and home health agencies. This redefinition initially applies to only ten high volume DRG's, to be defined by the Department of Health and Human Services, which account for a disproportionate use of post discharge services. This provision will be effective for FY 1999.

Recognizing that hospitals that admit, stabilize, and transfer patients to other hospitals generally use less resources than hospitals providing the full scope of medical treatment, distinctions were also made in the payment methodologies for discharges and transfers. While a hospital would receive the full DRG-based payment for a discharge, in a transfer situation the full DRG based payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred. The per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a non-transfer situation by the geometric mean length of stay for the DRG into which the case falls. The first day of the stay is paid at two times the per diem rate.

The OIG has identified overpayments which occurred because transfers between PPS hospitals were erroneously reported and paid as discharges. It is important that providers develop policies and procedures that outline the process for determining the proper discharge status code and that compliance audits are implemented to verify the accuracy of the coded information.

Coverage of Non-FDA Approved Devices

Section 1862(a)(1)(A) of the Social Security Act states, in part, that no payment may be made under Part A or Part B for any expenses for items or services that are not "reasonable and necessary" for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Medicare has historically interpreted the statutory terms "reasonable and necessary" to mean that a service must be safe and effective, and not experimental. For Medicare coverage purposes, the term experimental is used synonymously with the term investigational.

Medicare must apply the "reasonable and necessary" provision to medical devices as set forth in section 3151.1 of the Intermediary Manual, section 2303.1 of the Medicare Carriers Manual, and section 260.1 of the Hospital Manual. Those sections, whose wording is identical, read as follows:

> "*Medical devices which have not been approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services using devices which have not been approved for marketing by the FDA.*"

This policy applies to any device that is subject to FDA review. Additionally, other manual instructions exclude coverage of services related to an investigational service/device by stating:

> "*Services related to non-covered services, such as cosmetic surgery or non-covered organ transplants/implants, including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered under Medicare.*"

National policy not only precludes coverage of investigational devices and services using such devices, but also services related to the use of investigational devices when they are provided as part of an otherwise covered hospital stay. Payment outcomes that may occur when an investigational device is implanted during a hospital stay are as follows:

- If the patient is admitted for a medically appropriate reason and it is decided after the admission to implant an investigational device, Medicare would not pay for the surgical procedure. The hospital would be paid for a non-surgical admission under the appropriate diagnosis-related group (DRG). In effect, payment for items and services related to implantation would be excluded, but payment may be made for care rendered during the hospital stay that is not related to the implantation.
- If the admission is for the purpose of implanting an investigational device, the entire hospital stay is denied and no payment is made.
- The physician's services related to implantation of an investigational device are not covered regardless of the circumstances.

Certain unapproved devices may be allowed under an investigational device exemption (IDE). If approved, the IDE will permit the device to be available in a limited number of sites, for a limited number of patients, and under the supervision of identified researchers.

Providers may bill for these limited investigational devices, although FDA regulations prohibit manufacturers or investigators from charging a price higher than the costs of manufacture, research, development, and handling for any investigational devices.

Special Issues For Part B Providers

"Incident To" Provision

Medicare Part B covers services rendered by employees of physicians or physician directed clinics when the services provided are an integral, although incidental, part of the physician's professional service. To meet the requirements of this provision for services billable to the contractor, certain conditions must be met:

- The services and supplies are commonly furnished in an office **and**;
- The services are furnished as an integral, although incidental, part of the physician's professional services in the course of the diagnosis or treatment of an injury or illness **and require direct personal physician supervision**; **and**
- A valid employment arrangement must exist between the physician/clinic and the employee. This may be accomplished by employing a full-time, part-time or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician.

Office Setting or Physician Directed Clinics

These services are rendered under **direct supervision of the physician** (the physician must be in the office or office suite **and** immediately available to provide assistance to the employee providing the service).

Services in a Hospital Setting or Other Facility

These settings present a special problem in determining whether direct physician supervision exists when the non-physician services are rendered in a facility, but outside the physician's office.

Medicare cannot assume the physician and non-physician will be in close proximity to one another. Therefore, the services of the employee which are furnished in an institution (e.g., skilled nursing facility or nursing home) can be covered only if the physician accompanies the employee to treat the patient and directly supervises the services. Thus, in effect, the physician is providing **"over the shoulder"** supervision. For hospital patients, there is no Medicare coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services. Such services can be covered only under the hospital outpatient or inpatient benefit and payment for such services can be made only to the hospital by a Medicare intermediary (i.e., Medicare Part A benefits).

Home Care

If the physician is present, the same rules which apply in an office setting apply to the patient's personal residence. However, if the physician is not present at the patient's home, certain rules apply.

Medicare may reimburse services provided "incident to" a physician's professional service(s) in the patient's home when the following conditions are met:

- The patient resides in a medically underserved area and no **Home Health Agency** operates in the patient's area nor is available in a timely manner. (A list of medically underserved areas is available through your local Medicare contractor or HCFA), **and**
- The patient is homebound and unable to travel for routine medical services, **and**
- The employee is under **general supervision** of the physician. (This means the physician must be immediately available by telephone to collaborate with the employee providing the service.), **and**
- Only limited, defined services can be provided in the patient's home.

Only those services supervised (either direct or over the shoulder) by the physician are billable to Medicare. Any non-supervised services are not billable to Medicare nor to the patient. All requirements noted in the office setting also apply to services in a facility setting. Deviation from the rules and guidelines may be considered fraud or abuse.

Services by Non-Physician Practitioners

There are separate provisions of Medicare law which allow coverage for services by certain non-physician practitioners (e.g., advanced registered nurse practitioners, physician assistants, licensed clinical social workers, etc.) **without** the direct supervision of a physician. However, there may be specific coverage restrictions and/or billing requirements and reduced payment amounts for these practitioners. For example, coverage may be limited to certain settings or specific services and reimbursement may be less than what Medicare would allow for a physician for the same service.

Nonetheless, if services by non-physician practitioners are to be reported and covered under the "incident to" provision, then the requirement of direct physician supervision applies as well as all the other "incident to" requirements.

Teaching Physician Guidelines [IL 372]

Guidelines were revised by HCFA for teaching physicians (i.e., physicians [not a resident] who involve residents in the care of their patients) for services rendered on or after July 1, 1996. These guidelines require the presence of a teaching physician during the key portion of the service in which a resident is involved and for which Medicare payment will be sought. In cases of surgical, high risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure. Medicare will pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident; or
- The services are furnished jointly **or** by a resident in the presence of a teaching physician with certain exceptions that need to be determined on a case by case basis.

Other Issues

Unacceptable Billing/Coding Practices

Medicare is constantly publishing examples of fraud and abuse involving billing and coding. The most common involve unbundling, upcoding, duplicate billing, overcharging and unfair competitive practices. Here are a few specific examples:

- A laboratory agrees to pay a physician for every patient referred for a specific study. This is a kickback situation and is prohibited by federal law.
- A hospital, clinic or independent laboratory unbundles a panel laboratory test to obtain a higher reimbursement.
- A hospital or outpatient clinic bills Medicare for a non-covered service using a revenue code that is covered under the Medicare program.

Upcoding

Upcoding is a potentially fraudulent activity which involves submitting claims to Medicare for services, supplies or equipment which are reported with procedure or revenue codes that describe more extensive services/items than those actually furnished. That is, the services/items furnished may be covered by Medicare; however, the codes reported represent payment amounts that are higher than what should be allowed for the services/items that were furnished.

Providers receiving Medicare payment are responsible for having the appropriate procedures in place to ensure that all coding reported on Medicare claims reflect the standards set forth by Medicare.

Providers are responsible for the practices and procedures which generate the billing documents for payment, including the activities of billing staff and billing agencies. The provider must know whether the

service is covered, medically necessary and reasonable for the treatment of the patient's condition, and how to document and properly report the service to Medicare.

Non-Covered Services

There is no Medicare payment associated with the following procedures; therefore, you may charge the patient what is appropriate without providing a written advance notice of Medicare's denial of payment. These services include but are not limited to:

- Routine physicals/screenings,
- Non-payable screening tests with no symptoms or documented conditions (exceptions: there are certain screening tests which may be covered under the Medicare program [e.g., screening pap smears, screening mammographies]),
- Personal convenience items,
- Care provided in facilities located outside of the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianna Islands,
- Custodial care,
- Outpatient oral medications, self-administered drugs,
- Routine foot care,
- Prophylactic dental care,
- Exams for purposes of prescribing a hearing aid or eyeglasses, or
- Cosmetic surgery.

Medically Unnecessary Services

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services will be denied. Providers who do not want to assume financial responsibility for the denied service(s) should give the patient an acceptable written advance notice of Medicare's denial of payment.
These services include but are not limited to:

- Services provided in a hospital or skilled nursing facility (SNF) that based on the condition of the patient could have been provided elsewhere (such as the home or a nursing home);
- Evaluation & Management (E/M) services provided in excess of what is considered medically reasonable and necessary; and
- Therapy or diagnostic procedures provided in excess of medical need.

Services Bundled in the Basic Allowance

There are services which are considered included in the basic allowance of another procedure and cannot be charged to the patient. Whenever a provider attempts to unbundle these codes for an increase in reimbursement, this action may be considered fraud or abuse.

Chapter 4 – Legislative Update

In May 1995, President Clinton announced a new partnership between federal and state agencies to crack down on Medicare and Medicaid fraud, waste, and abuse. The targeted anti-fraud project, known as **Operation Restore Trust (ORT)**, initially focused on New York, Florida, Illinois, Texas, and California. These states account for approximately 40 percent of all Medicare and Medicaid beneficiaries. ORT has expanded to include other states as well.

The Department of Health and Human Services (DHHS) is leading these efforts. In addition, the Health Care Financing Administration (HCFA), the Office of the Inspector General (OIG), the Administration on Aging (AOA), the Department of Justice (DOJ), and the Medicare contractors participate in ORT. Target areas for ORT include partnering the relationships between law enforcement agencies, data analysis and sharing of data, and educating the public about Medicare and Medicaid fraud and abuse.

Savings include court awards in fraud cases and decreased billings for fraudulent and wasteful practices. The project is designed both to alert the public and industry to fraudulent activities and to penalize those who defraud the government.

ORT also identifies and corrects vulnerabilities in the Medicare and Medicaid programs. Involving the public is a key part of this effort. The public can report suspected fraud and abuse by calling the Medicare contractor or the following special toll free hotline: **1-800-HHS-TIPS**.

A voluntary disclosure program included in the ORT project allows providers or other entities to come forward to law enforcement or the Department of Justice with evidence of fraud or errors within their own organizations and may receive consideration for reduced penalties.

False Claims Act

The False Claims Act prohibits knowingly filing a false or fraudulent claim for payment to the government, knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government, or conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

See 31 U.S.C. 3729(a) of the Act for additional details/exclusions/statutory exceptions.

The Anti-kickback Statute

The Anti-kickback Statute prohibits:

- Soliciting or receiving remuneration for referrals of Medicare or Medicaid patients, or referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid;
- Soliciting or receiving remuneration in return for purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering any goods, facility, service or item for which payment may be made in whole or in part, by Medicare or Medicaid;
- Offering or paying remuneration for referrals of Medicare or Medicaid patients or for referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid; and
- Offering or paying remuneration in return for purchasing, leasing, ordering, arranging for or recommending purchasing, leasing, or ordering any goods, facility, service or item for which payment may be made, in whole or in part, by Medicare or Medicaid.

Discounts, rebates, or other reductions in price may violate the anti-kickback statute because such arrangements induce the purchase of items or services payable by Medicare or Medicaid. However, certain arrangements are clearly permissible if they fall within a "safe harbor." One safe harbor protects certain discounting practices. For purposes of this safe harbor, a "discount" is the reduction in the amount a seller charges a buyer for a good or service. In addition, to be protected under the discount safe harbor, the discount must apply to the original item or service which is purchased or furnished. That is, a discount cannot be applied to the purchase of a different good or service than the one on which the discount was earned. A buyer is the individual or entity responsible for submitting a claim for the item or service which is payable by Medicare or Medicaid. A seller is the individual or entity offering the discount.

A "rebate" is defined as a reduction in price which is not given at the time of sale. Because this reduction in price is not given at the time of sale, a rebate is **not** protected by the discount safe harbor.

See 42 U.S.C. 1320a - 7(b)b of the Act for additional details/exclusions/statutory exceptions.

Safe Harbors

Safe harbor provisions protect certain individuals, providers or entities from criminal prosecution and/or civil sanctions (when certain requirements are met) for actions which may appear as unlawful or inappropriate according to Medicare law.

The Department of Health and Human Services established the "Safe Harbors for Protecting Health Plans" in accordance with the Medicare and Medicaid Patient and Program Protection Act of 1987 (as published in the November 5, 1992 Federal Register). The safe harbors are updated annually to consider changes to medical delivery systems and new financial relationships. Comprehensive information on the safe harbor provisions can be obtained from the Code of Federal Regulations (42 CFR 1001.92). The safe harbors provision includes:

- Protection for certain incentives to enrollees (including waiver of coinsurance and deductible amounts) paid by health care plans.
- Protection for certain negotiated price reduction agreements between health care plans and contract health care providers.

Price Reductions Offered to Health Plans

Typically, health care providers will contract with health plans and agree to furnish items and services to enrollees of the health plan at a discount from the provider's usual fee in return for obtaining a large volume of patients. Three prerequisites were established for these safe harbors to apply:

- The protected remuneration is the contract health care provider's reduction of its usual charge for the services;
- The terms of the agreement between the parties must be in writing; and
- The agreement must be for the sole purpose of having the contract health care provider furnish to enrollees items or services that are covered by the health plan, Medicare or Medicaid.

Physician Self-Referral Laws

In January 1995, Congress passed a law which prohibits certain physician self-referrals in the context of the Medicare and Medicaid programs. Section 1877 of the Social Security Act (42 USC Section 1395nn) states that physicians cannot make self-referrals for certain designated health services (DHS). DHS include any of the following items or services:

- Clinical laboratory services;

- Physical therapy services;
- Occupational therapy services,
- Radiology services, including MRI, CAT scans, and ultrasound services;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient/outpatient hospital services.

What Does Stark II Prohibit?

The law prohibits a physician or his immediate family members from having a financial relationship with an entity to which Medicare patients are referred to receive a designated health service. A financial relationship can exist as an ownership or investment interest in or a compensation arrangement with an entity.

Penalties for Violating the Law

The civil monetary penalty is a maximum of $15,000 for each service billed or furnished as the result of a prohibited referral. A total maximum penalty of $100,000 can be applied for each scheme to evade the requirement.

Defining Financial Relationship/Referrals

A physician has a financial relationship with an entity if he or she (or an immediate family member) has an ownership/investment interest in that entity or a compensation arrangement with the entity. An ownership/investment interest may be through equity, debt or other means. A compensation arrangement exists when there is any arrangement in which payment of any kind passes between a physician or immediate family member and an entity. Also, if a physician refers services to the facility or refers services to a company with which immediate family members have financial relationships, an improper referral exists.

Exceptions

Exceptions related to compensation arrangements include:

- Payments for the rental of office space or equipment;
- Payments to a physician/family member that has a bona fide employment relationship with the entity;
- Payments to a physician/family member for personal services;
- Payments involved in an isolated financial transaction;
- Payments made by a hospital to a physician if the payments do not relate to DHS;
- Payments made by a hospital to recruit a physician;
- Certain payments resulting from a group practice’s arrangements with a hospital when DHS are provided by the group; or
- Payments by a physician to an entity for items and services.

Exceptions related to ownership or investment interests include:

- Ownership in certain publicly traded securities and mutual funds;
- DHS provided by a hospital in Puerto Rico;
- DHS furnished by a rural provider; or

- DHS provided by a hospital outside of Puerto Rico if the referring physician can perform services at the hospital and the ownership/investment interest is in the whole hospital (not in a subdivision of the hospital).

Exceptions related to **both** ownership or investment interests and compensation arrangements include:

- Physician's services when a physician refers to a member of the same legitimate group practice;
- Certain in-office ancillary services furnished by solo practitioners and group practices; or
- Services furnished by certain organizations with prepaid plans.

The law also clarifies several exemptions to the existing clinical laboratory ban. For example, the law places restrictions on the exemption for group practices by specifically requiring that members of the group provide at least 75% of the physician-patient encounters in the practice, limiting the use of contract employees.

Because most of the exceptions noted above have various limitations and conditions, it is very important to consult an attorney regarding the full scope of the statute.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy-Kassebaum bill, was enacted on August 21, 1996. Among other provisions, the Act is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The Act also imposes significant changes to anti-fraud and abuse activities. These provisions of HIPAA use a four-pronged approach to combat health care fraud, waste, and abuse: education, extended coverage, enhanced enforcement and expanded penalties.

Provisions to Improve Education

- **Advisory Opinions -** The OIG is authorized to issue advisory opinions to individuals or entities regarding the legality of specific activities and transactions under the Anti-Kickback Statute.
- **Safe Harbors and Fraud Alerts -** The OIG is required to solicit for proposals from the public for modifying existing safe harbors, establishing new safe harbors, issuing special fraud alerts, and rendering advisory opinions. In addition, requests may be submitted to the OIG at any time for issuance of special fraud alerts regarding practices that the OIG considers suspect or of particular concern. The OIG is obligated to investigate the merits of such proposals and requests.
- **Beneficiary EOMBs -** The DHHS is required to issue Medicare beneficiaries "explanations of benefits" for each Medicare covered item or service. The theory seems to be that EOMBs, by informing beneficiaries of payments made, will assist the beneficiaries question and report to Medicare apparently improper billing.
- **Incentives for Efficiency Suggestions -** Individuals are permitted to submit suggestions to the DHHS on methods to improve efficiency in the Medicare program. Financial awards may be given to those whose suggestions are adopted and result in program savings.
- **National Data Bank -** The DHHS must establish a national data bank to record information about providers and suppliers that have committed health care fraud or abuse. The data bank is open to federal and state law enforcement, health care licensing and health plan administrative agencies, and to private health plans.

Provisions to Extend Coverage

- **Health Care Fraud Crimes –** "Health care fraud" is now an independent federal crime that protects both public and private health plans. This federal crime outlaws knowing and willful

schemes to defraud or obtain by false pretenses money or property of any health care benefit program, not just Medicare or Medicaid. “Health care benefit program” is defined as “any private or public plan or contract providing medical benefits, items, or services.”

- **All Federal Health Programs -** The criminal prohibition against illegal remuneration and false statements and claims of the Anti-Kickback Statute are extended beyond Medicare and Medicaid to all federal health care programs (except the Federal Employee Health Benefit Program).
- **Waiver of Copayments and Deductibles** - Waiver of any part of coinsurance or deductibles, or transfer of items or services for free or for less than fair market value is “remuneration” which exposes persons and organizations to civil monetary penalties and permissive program exclusion if the conduct is likely to influence beneficiaries to order an item or service paid by Medicare or Medicaid.
- **Fraudulent Disposition of Assets -** It is now a federal crime to knowingly and willfully dispose of assets, including by “transfer in trust,”to become eligible for Medicaid.

Provisions to Enhance Enforcement

- **Medicare Integrity Program -** The DHHS is authorized to contract with eligible private organizations, as well as Medicare contractors, to review and audit provider activities and otherwise assure the integrity of the Medicare program.
- **Public and Private Enforcement Coordination -** To improve law enforcement, the OIG and the Department of Justice are directed to implement programs that coordinate federal, state, local and private activities to combat health care fraud and abuse. The programs are supposed to facilitate investigations, audits and inspections of health care delivery and payments, and enforcement of criminal, civil and administrative fraud and abuse controls.
- **Assured Enforcement Funding -** Funding for effective implementation of the government’s expanded fraud and abuse control programs is assured by the creation of a “Health Care Fraud and Abuse Control Account” within the Federal Hospital Insurance Trust Fund.
- **Bounties -** The DHHS is authorized to pay awards to individuals who report Medicare fraud and abuse activities which result in the collection of fines, penalties, or overpayments.
- **Investigative Subpoenas -** The Department of Justice is authorized to issue investigative subpoenas in connection with investigations of health care fraud crimes. These subpoenas can require the production of records and other documents and the testimony of their custodians.

Provisions to Expand Penalties

- **Mandatory Program Exclusions -** Persons or organizations may be excluded from Medicare or Medicaid if they are convicted of felony fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care items or services or with respect to acts or omissions in any health care program operated or financed at least in part by any federal, state, or local government agency, as well as for felony conviction relating to controlled substances.
- **Permissive Program Exclusions -** Persons or organizations may be excluded from Medicare or Medicaid if they are convicted of misdemeanor fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care items or services or with respect to acts or omissions in any program - health care or otherwise - operated or financed at least in part by any federal, state, or local government agency.
- **Owner, Manager and Provider Exclusion -** Individuals who own or control sanctioned organizations and who know or should know of the sanctionable conduct are subject to permissive program exclusion.

- **HMO Intermediate Sanctions -** HMOs that fail to comply with their Medicare contracts are now subject to intermediate sanctions, such as fines and suspension, as an alternative to contract termination.
- **Civil Monetary Penalties -** The DHHS's authority to impose civil monetary penalties is extended to fraud and abuse affecting, not only Medicare and Medicaid, but other federally funded health care benefit programs. In addition, civil monetary penalties have been increased from $2,000 to $10,000 and from double to triple the amount of improper or excess reimbursement claimed.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 was signed into law on August 5, 1997. The law makes numerous changes to the various titles of the Social Security Act, as well as creating a new Title XXI which is the State Children's Health Insurance Program.

The Act includes several anti-fraud and abuse provisions and improvements in protecting program integrity. The following are some of the new provisions:

Permanent Exclusions

This provision excludes from Medicare or any State health care program for at least 10 years, an individual who has been convicted on one previous occasion of one or more health care related crimes for which a mandatory exclusion could be imposed, including Medicare and state health care program related crimes, patient abuse, or felonies related to health care fraud or controlled substances. It also permanently excludes an individual who has been convicted on two or more previous occasions of such crimes.

Authority to Refuse to Enter Into Agreements

This provision authorizes the DHHS to refuse to enter into, renew an agreement or terminate an agreement with a provider if the provider has been convicted of a felony under Federal or State law for an offense which the DHHS determines is inconsistent with the best interests of the program or program beneficiaries.

Exclusion of Entity Controlled by Family Member

This provision authorizes the DHHS to exclude from Medicare or any State health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following a conviction, assessment, or exclusion.

Imposition of Civil Monetary Penalties

This provision provides that a civil monetary penalty of up to $10,000 may be levied when a person arranges or contracts with an individual or entity for the provision of items or services when it knows or should know that the individual or entity has been excluded from a federal health care program. The individual or entity would also be subject to an assessment of up to three times the amount claimed and to exclusion from Federal health care programs.

A civil monetary penalty of up to $50,000 plus up to three times the amount of remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions.

Anti-Fraud Message in Medicare Handbook

This provision states that the Medicare Handbook must contain:

- a statement indicating that errors occur and that Medicare fraud, waste and abuse is a significant problem;
- statements encouraging beneficiaries to review their Medicare Summary Notices or statements for accuracy and to report any errors or questionable charges;
- a description of a beneficiary's right to request an itemized statement from their provider for Medicare items and services;

- a description of the beneficiary Incentive Reward Program established under HIPAA; and
- DHHS OIG toll-free hotline number which receives complaints and information about fraud, waste, and abuse.

Disclosure of Information and Surety Bonds

This provision states that durable medical equipment (DME) suppliers, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs) and rehabilitation agencies would be required to provide a surety bond of at least $50,000.

DME suppliers would also be required to identify each person with an ownership or controlling interest in the supplier or any subcontractor in which the supplier has a direct or indirect ownership interest of five percent or more.

The DHHS may waive the law if the DME supplier, HHA, CORF, or rehabilitation agency provides a comparable bond under State law or the DHHS may elect to impose disclosure of information and surety bond requirements on Part A providers, suppliers, or other persons (other than physicians and other practitioners).

Beneficiary Right to Itemized Statements

This provision gives Medicare beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any item or service furnished. Providers/suppliers must furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of $100 for each unfulfilled request. In addition, the provider/supplier may not charge the beneficiary for the itemized statements.

Chapter 5 – Quick Self-Checks

Here are quick self checks to see how protected you are from Medicare fraud and abuse. *Questions that cannot be answered correctly may need to be addressed.*

A. General Self-Check Questions

1. When disposing of records, do you shred or otherwise destroy reports which include patient names and Medicare numbers?

Yes No

2. Do you advertise that you will waive Medicare coinsurance/ deductible amounts or that the patient will "owe nothing" even if they do not have a Medicare supplement?

Yes No

3. Do you review the reports of sanctioned individuals and entities to assure that physicians in your group or on your medical staff who are sanctioned are not providing services to your patients, **and** to assure that those individuals and entities from whom you order tests or refer patients are not sanctioned as well?

Yes No

4. Is your provider number kept confidential and shared only with those with an operational need to know?

Yes No

5. Do you carefully review all documentation before certifying the medical necessity of services or supplies needed by your patients?

Yes No

6. If you have authorized someone else to bill Medicare for your services, do you have a process in place to ensure those billings accurately reflect the services furnished?

Yes No

7. Have you done proper background checks on companies/people you have contracted with/hired?

Yes No

8. Do you have a process in place to effectively keep up with changes released in Medicare's publications?

Yes No

9. Do you periodically check to ensure that services you order for patients are the only ones actually performed and billed to Medicare?

Yes No

10. Do you notify Medicare and/or the state licensing agency prior to making any changes to the location of your business?

Yes No

11. Do you personally read and understand all agreements and contracts related to your Medicare business before signing them?

Yes No

12. Do you document fully the services you bill/order for Medicare beneficiaries and do you have a process for maintaining your records?

Yes No

13. Do you allow billing staff to make changes to the billing record without your prior approval?

Yes No

14. Have you examined all your business relationships for any conflicts with the Stark/self referral and anti-kickback provisions?

Yes No

15. Do you have internal audits in place to detect billing inaccuracies promptly?

Yes No

B. Self Check for Part A Providers

1. Do you have a system in place to identify patients receiving outpatient services within 24 hours of an inpatient stay?

Yes No

...within 72 hours?

Yes No

... are the appropriate outpatient charges/codes combined with those for inpatient services?

Yes No

2. Do you verify that the devices purchased and used by your facility have received approval from the FDA?

Yes No

3. Do you audit the medical record discharge status with that on the patient bill?

Yes No

4. As a Medicare provider, do you continue to charge the Medicare inpatient deductible for patients in exempt psychiatric and rehabilitation units paid under TEFRA?

Yes No

5. If a patient receives an investigational device during an otherwise medically appropriate admission, is the surgical procedure to implant the device included in the coding for the DRG?

Yes No

6. Does your charge master include non-covered services under the Medicare program with a revenue code that is covered?

Yes No

7. Do you bill the Medicare program for self-administrable drugs provided to hospital outpatients?

Yes No

8. Do you have a policy in place that ensures pre-operative services are performed within the appropriate window for inpatient bundling?

Yes No

9. Do you have a process in place that identifies if canceled services are charged to the patient account?

Yes No

10. Do you have a program set up that requires periodic and routine re-credentialing of your medical staff?

Yes No

C. Self Check for Part B Providers

1. Have you informed Medicare if your physical address or phone number has changed for either your primary provider number or for any of your suffixes?

Yes No

2. Do you have a process in place to ensure a diagnosis reported is appropriate for the services rendered?

Yes No

3. Do you question lab requisition forms that list only “panels” and do not list the specific tests you need individually?

Yes No

4. Do you ever sign blank forms like certificates of medical necessity?

Yes No

5. Do you monitor your lab test results to ensure they are consistent with the tests you ordered?

Yes No

6. Do you have internal procedures to ensure that the E & M codes billed are documented to support the scope of services described under the particular procedure code?

Yes No

7. When you bill for "incident to" services, do you provide the appropriate type or level of physician supervision based on the place where the service was performed?

Yes No

8. Do you ever advertise "free" services that are subsequently billed to Medicare?

Yes No

9. Do you pay your billing service based on an "incentive" arrangement?

Yes No

Keys for Self Test

A. General Self Check Questions

1) Y
2) N
3) Y
4) Y
5) Y
6) Y
7) Y
8) Y
9) Y
10) Y
11) Y
12) Y
13) N
14) Y
15) Y

B. Self Check for Part A Providers

1) Y/Y/Y
2) Y
3) Y
4) Y
5) N
6) N
7) N

8) Y
9) Y
10) Y

C. Self Check for Part B Providers

1) Y
2) Y
3) Y
4) N
5) Y
6) Y
7) Y
8) N
9) N

Chapter 6 – Fraud & Abuse Resources

Reporting Fraud Or Abuse

If you suspect Medicare fraud or abuse, please call your Medicare contractor, or

you may call the OIG directly to report fraud or abuse nationally at:

1-800-HHS-TIPS

To obtain information about correct coding combinations:

AdminaStar Federal
P.O. Box 50469
Indianapolis, IN 46250

or

National Technical Information Service
(800) 553-6847 and ask for PR 1030, which is a list of publications about the Correct Coding Initiative.

You may also visit their web site at:

www.ntis.gov

Closing or Relocating Practices

Medicare Part A Providers:

Part A providers who want to obtain application information or make changes to their existing application/file, must contact the state agency responsible for licensure and certification.

Medicare Part B Providers:

Part B providers who decide to close or move their practice, should inform their Medicare contractor. Your PIN will need to be updated in the Medicare computer system so it cannot be used by anyone else.

Internet Access

The entire GSA debarment, exclusion, and suspension list is accessible on the internet at:

www.arnet.gov/epls/

DHHS also has an internet website that not only has a database of all sanctioned providers, but also carries information pertaining to HCFA and OIG updates. It is accessible on the internet at the following address:

www.hhs.gov

Computer Based Training

There is also a computer based training module available on Fraud and Abuse. Please visit the Medicare Learning Network's web site to download your FREE copy. The internet address is:

www.hcfa.gov/medlearn/cbts.htm

Again, your help in combating Medicare fraud and abuse is greatly appreciated.

Chapter 7 – Terms You Should Know

The following list of terms are defined in relation to Medicare:

A

Abuse - Any incident or practice of a provider, physician, or supplier which, although not usually considered fraudulent, is inconsistent with accepted and sound medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or program reimbursement for services that fail to meet professionally recognized standards of care or, in some cases, may be medically unnecessary.

Adjudication - The process of deciding whether to allow or deny a claim based upon the information submitted and the eligibility of the recipient. For claims to be paid, the determination of the amount to be allowed is based on the contract, type of coverage and prior utilization.

Adjustment - Additional payment or correction of records on a previously processed claim.

Admission - Entry to a hospital or other health care institution as an inpatient.

Appeal Request - Written statements that convey an explicit or implicit request for a review of the initial determination, or conveys dissatisfaction with the most recent determination made related to a claim.

Approved Charge - The amount that Medicare has determined is appropriate for payment.

Assignment - A process in which a Medicare beneficiary agrees to have Medicare's share of the cost of a service paid directly to the provider. The provider agrees to accept the Medicare approved charges as payment in full.

B

Beneficiary (Bene) - Person entitled to Medicare benefits under the Social Security Administration.

C

Carrier - An insurance company that contracts with HCFA to provide claims processing and payment for Medicare Part B services.

Claim - Forms submitted, or the electronic submission of information, for payment of medical services and supplies provided to Medicare beneficiaries.

Co-insurance - A type of cost-sharing where the insured party and insurer share payment of the allowed charge for covered services in a specified ratio, which occurs after payment of the deductible is made by the insured.

Contractor - A contractor for Medicare purposes is defined as a Fiscal Intermediary (FI), Carrier, Durable Medical Equipment Regional Carrier (DMERC), or Regional Home Health Intermediary (RHHI).

Covered Services - Services rendered to Medicare or Medicaid patients that are reimbursable by the program to the provider.

CPT/ Current Procedural Terminology - The coding system for healthcare services developed by the CPT Editorial Panel of the AMA.

D

Date of Service - The date the services were actually performed.

Deductible - Amount that must be paid by an insured person before an insurance plan pays any portion of the associated costs.

Diagnosis - Identifies the condition, cause or disease of the patient.

Diagnostic - Procedures used to discover the nature and underlying cause of illness.

Durable Medical Equipment (DME) - Medical equipment that is intended to be used over and over again, usually by the patient or care giver, rather than being used once or a few times and then discarded. Examples include wheelchairs, hospital beds and oxygen tanks.

Durable Medical Equipment Regional Contractor (DMERC) - An insurance company that contracts with HCFA to provide Medicare claims processing and payment for supplies, DME, prosthetics and orthotics.

E

Electronic Media Claims (EMC) - A communications process where claims are sent electronically from a computer to a claims processing center. EMC allows you to bypass several steps of the paper claims process by eliminating the need for mail room processing and manual data entry by claims examiners.

Entitlement - Refers to a Medicare beneficiary who can receive benefits under the Medicare program (e.g., the date of entitlement begins at age 65 for most beneficiaries).

Exclusions - A provision in the law stating situations or conditions under which coverage is not afforded by the subscribers' contract. Or, can describe penalty imposed by DHHS, OIG on providers prohibiting them from billing Medicare or other government programs.

Experimental or Investigative - Any treatment, procedure, equipment, drugs, drug usage, or devices not approved by the FDA.

F

Fair Hearing - An independent determination related to claims for which the party has appealed the review decision within six months of the date of notice of that decision. This independent determination is rendered by a Hearing Officer assigned by the contractor. A party is entitled to a Fair Hearing if the amount in controversy is at least $100.

Fee Schedule - A list of certain services and payable amounts indicating the maximum Medicare payment for the service (e.g., clinical lab and durable medical equipment).

Fiscal Intermediary (FI) - An insurance company that contracts with HCFA to process Medicare Part A bills (hospital insurance).

Fraud - Intentional deception or misrepresentation which an individual or entity makes, knowing it to be false and that the deception could result in some unauthorized benefit.

H

Health Care Financing Administration (HCFA) - The part of the Department of Health and Human Services that administers and oversees the Medicare program and a portion of the State Medicaid program.

Health Care Financing Administration Common Procedure Coding System (HCPCS) - A Medicare coding system for describing services based on the American Medical Association's (AMA) CPT descriptors, but supplemented with additional codes. It includes three levels of codes as well as modifiers. This coding system is designed to incorporate all medical services, to be universal, and to be consistent with the AMA's CPT coding system.

Health Insurance Claim Number (HICN or HIC) - Refers to the number issued by the Social Security Administration to a person covered under the Medicare program.

Health Maintenance Organization (HMO) - A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers.

Home Health Agency - An approved association or organization where a Medicare patient who is home bound receives skilled nursing and/or therapeutic care in the home.
Hospital - Institution with organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services.

Hospital Based Physician - An MD or DO under contract or arrangement to provide service in a hospital setting, salaried or unsalaried, who renders treatment or services in the hospital environment.

I

Inpatient - One who occupies a regular hospital or other institutional bed while receiving care, including room, board and general nursing.
Intermediaries - Private organizations, usually insurance companies, that have contracts with the Health Care Financing Administration to process claims under Part A (hospital insurance) of Medicare.

International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) - A national coding method to enable providers to effectively document the medical condition, symptom or complaint which is the basis for rendering a specific service(s). This coding system consists of three to five digit numeric or alphanumeric codes for reporting purposes.

L

Licensed Physician - A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who is legally qualified to practice medicine and who is qualified to direct a treatment plan.

Limiting Charge - The maximum amount that a nonparticipating physician and certain suppliers are permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993, the limiting charge was set at 115% of the Medicare allowed charge.

M

Medicaid - A federal/state program, established by Title XIX of the Social Security Act. A program of federal matching dollars to the states to provide health insurance for categories of the poor and medically indigent.

Medical Review - A process that includes the application of medical criteria, knowledge, or judgement to ensure that payments are made for items/services that are covered, appropriate, and medically necessary.

Medically Necessary Services - Those services determined by Medicare to be:

consistent with symptoms or diagnosis and treatment of the insured's condition, disease, ailment or injury;
appropriate with regard to standards of good medical practice;
provided not primarily for the convenience of the insured, the hospital or the physician; and
the most appropriate level of service that can be safely provided.

Medicare Fee Schedule - The resource-based fee schedule which Medicare utilizes to reimburse/pay for physician, laboratory, and supplier services.

Medicare Part A - Part of the Medicare program which reimburses a portion of facility charges for beneficiaries who receive services from certain institutions, such as hospital (inpatient and outpatient), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), and end-stage renal dialysis (ESRD) facilities.

Medicare Part B - Part of the Medicare program which reimburses covered physician and supplier services rendered in various places, such as a doctor's office, outpatient hospital, patient's home, nursing home, etc.

Medicare Remittance Notice (MRN) - A summarized statement for providers which includes payment information for one or more beneficiaries. Formerly called Provider Claims Summary (PCS).

Medicare Summary Notice (MSN) - A statement sent to a Medicare beneficiary which indicates how Medicare processed the claim.

Medigap Policy - Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance, and balance bills, as well as payment for services not covered by Medicare.

N

National Provider Identifier (NPI) - A unique number assigned to each Medicare provider.

Non-Assigned Claim - A claim potentially payable directly to the Medicare beneficiary.

Non-Participating Provider - A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on Medicare claims.

O

Outpatient - A member receiving hospital care but not occupying a regular hospital bed or receiving room, board and general nursing care.

Overpayment - An overpayment occurs when Medicare has paid a physician, provider or facility more money than what should have been paid.

P

Participating Physician and Supplier Program (PAR) - A program that provides financial and administrative incentives for physicians and suppliers who agree in advance to accept assignment on all Medicare claims.
Participating Physician - A physician who signs a participation agreement/contract agreeing to accept assignment on all claims submitted to Medicare for processing.

Patient - A person under treatment or care by a physician or surgeon or in a hospital.

Peer Review Organization (PRO) - An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries. Sometimes referred to as a Quality Improvement Organization (QIO).

Provider - A generic term for any person (e.g., a physician) or entity (e.g., a home health agency, a skilled nursing facility, a hospital, etc.) approved to provide/give care to Medicare beneficiaries and to receive payment from Medicare.

Provider Claim Summary (PCS) - A summarized statement for providers which includes payment information for one or more beneficiaries. Now called Medicare Remittance Notice (MRN).

Purchased Diagnostic Tests - A test (e.g., EKG, X-ray, ultrasound, etc.) purchased from an outside supplier for which a physician bills, but does not personally perform or supervise.

Q

Qui Tam - This is a provision in the law which allows persons having knowledge of a false claim against the government to bring an action in a Federal District Court for themselves on behalf of the United States Government.

R

Relative Value - Reflects the relativity in units of median charges among procedures, in any of the five major categories of medicine.

Reopening - A reevaluation of a claim determination. A reopening is not an appeal right. It is a discretionary action in response to the identification of an error, fraud or the submission of new material and information not available at the time of the last adjudication.

Review - The first formal level of appeal, following a denial of a claim.

S

Skilled Nursing Facility (SNF) - An institution or a distinct part of an institution, which has in effect a transfer agreement with one or more hospitals and is primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Social Security Administration (SSA) - The branch of the Department of Health and Human Services that operates the various programs funded under the Social Security Act. It also determines when an individual becomes eligible for Medicare benefits.

T

Title XIX - Medicaid program.

Title XVIII - Medicare program.

U

Unique Physician Identification Number (UPIN) - A unique number assigned to each Medicare physician, for identification purposes, regardless of the number of associations in which they may practice.

Utilization - The percentage of usage by Medicare patients of a given facility's, or health care provider's, services.

W

Waiver of Liability - A provision designed to protect the beneficiary from liability under certain conditions when the services furnished are found to be not reasonable and necessary.

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